EHR Frequently Asked Questions

1. Who is responsible for tracking patient encounters and calculating the EP's patient volume?
2. Will the patient volume be validated and if so, by whom?
3. If claims are not used to determine patient encounters, how should they be identified? Is there a report that can be run by an EHR?
4. Can Medicaid be the secondary insurer when determining total Medicaid patient encounters?
5. How will encounters be identified for a Nurse Practitioner that has services billed under one or more physicians in the practice?
6. If a Nurse Practitioner (NP) works in a pediatrician's office and the pediatrician only meets the 20% Medicaid patient volume, does the requirement for the NP to meet the 30% patient volume still apply?
7. If a Nurse Practitioner (NP) works in a Family Practice office where the physician patient volume threshold meets 30%, but the NP Medicaid patient volume is only 28% and bills under the physician, does the NP qualify for an incentive even though she does not meet the 30% patient volume?
8. I know at one point Behavior Health/Psychiatrist were excluded from being eligible physicians for HITECH. Is this still the case or are psychiatrists eligible?
9. What is the first step in getting started? Is there a number I can call for more information?
10. I noticed on your website that EPs must verify they have paid at least ($3,750 for year 1 and $1,500 for year 2 through 6). If a Hospital or Home Office paid for the technology, is the EP still eligible for incentive payments for EHR technology?
11. Is a PA in a FQHC eligible for incentives only if the PA is the patient's primary provider or does the PA have to be the primary provider of the FQHC?
12. If a patient's primary provider is a physician but the patient is occasionally seen by a PA, would the PA qualify for incentives?
13. Are PAs in physician offices, other than a FQHC qualified for incentives?
14. Is there any issue with EPs applying for Medicaid incentives and being associated with the same TIN as the hospital that will also be applying for MU incentives?
15. We know that the billing provider NPI # is used to verify patient volume for EPs that choose to use group encounters to meet eligibility requirements.

    a) Does this mean the TIN has no bearing on eligibility requirements?

    b) Will EPs use the billing provider NPI # for their main satellite office if they want to apply using group encounters or will they use the billing provider NPI#s of all 4 locations together?

    c) Several physicians practice at multiple locations. Will they use the billing provider NPI # of all locations where they work to calculate group patient volume?

    d) If a provider uses group volumes is the provider required to select the group as the payee?
16. If EP's in a group have attested to program year 1 and a new EP joins the group, can the new EP attest to AIU or will the EP be required to attest to MU?
17. As the non-EHR professionals adopt EHR technology (sharing the same TIN # as the EHR early adopters), will their Medicaid patient volume percentages affect the group practice volume percentages if the group practice qualifies as a group meeting the 30% Medicaid threshold?
18. One physician sees patients in a traveling van and all of his patients are considered charity care. Will he be eligible for Medicaid incentives based on the needy individual's definition: patients furnished uncompensated care by the provider or services at no cost?
19. For the first participation year, an EP only has to Adopt, Implement, or Upgrade an EHR to receive incentives. For the following years, the EP must meet certain objectives and measures during a specified EHR reporting period. For participation year 2 and later, if a physician practices at several locations, will all locations be taken into consideration to meet the objectives or will only the primary practice location be utilized?

    a. In order to demonstrate that at least 50% of all encounters occur in a location(s) where certified EHR technology is being utilized, must a provider include all locations even if a single location represents over 50% of the patient encounters?
20. For a FQHC, do free care encounters, charity care encounters, and sliding scale encounters count toward meeting the 30% eligibility requirement?

1. Who is responsible for tracking patient encounters and calculating the EP's patient volume?

Providers are responsible for tracking patient encounters. Calculation of the patient volume for program eligibility will be determined by the Division of Medicaid and Medical Assistance (DMMA) based on the encounter information entered by a provider through the DMAP incentive program web portal (MAPIR). Patient volume must be broken out for each Medicaid managed care company and for fee for service Medicaid claims. Providers that are working for more than one group and are claiming individual encounter volumes must list encounters from all groups. Return to Top

2. Will the patient volume be validated and if so, by whom?

The Division of Medicaid and Medical Assistance (DMMA) validates Medicaid encounters (numerator) through claim data for the reporting period. If the Medicaid encounters related to an EP are submitted by an MCO, and the EP's NPI is not on the encounter, the PIP team will request validation of the encounters from the MCO claims system. Providers will need to maintain adequate records that can validate the total patient encounters (denominator) reported from all sources. DMMA will audit individual providers to ensure program integrity. Additional information will be requested from providers to support the patient volume provided for program eligibility. Incentive payments are paid with Federal Funds. Falsification or concealment of a material fact may be prosecuted under Federal and State laws. Return to Top

3. If claims are not used to determine patient encounters, how should they be identified? Is there a report that can be run by an EHR?

DMMA expects providers will use claim data, panel volume, or some type of reporting from an EHR or Practice Management System to determine patient encounters. Total provider patient encounters could require data from several different sources. Return to Top

4. **Can Medicaid be the secondary insurer when determining total Medicaid patient encounters?**

Effective in 2013, there are Stage 2 changes for Medicaid enrolled encounters: Numerator to include service rendered on any one day to a Medicaid-enrolled individual, regardless of payment liability. This includes zero-pay claims and encounters with patients in the Title XXI funded Medicaid expansions, but not separate CHIP programs. Return to Top

5. **How will encounters be identified for a Nurse Practitioner that has services billed under one or more physicians in the practice?**

The performing provider NPI will be used to verify patient volume for professionals that choose to report their individual encounters to meet eligibility requirements of the incentive program. The billing provider NPI will be used to verify patient volume for professionals that choose to use the group encounters to meet eligibility requirements of the incentive program and that bill under the group NPI. Regardless of performing provider NPI, the billing NPI will represent all encounters for the group practice. Return to Top

6. **If a Nurse Practitioner (NP) works in a pediatrician's office and the pediatrician only meets the 20% Medicaid patient volume, does the requirement for the NP to meet the 30% patient volume still apply?**

Yes, the NP must meet the 30% patient volume. Medicaid patient volume required for program eligibility must be consistent with the type of professional applying. In this scenario, the NP needs to have a 30% Medicaid patient volume and the Pediatrician must have a 20% patient volume, even if the professionals are using the group encounter volume to meet program eligibility. The NP qualifies for the full incentive and the Pediatrician qualifies for 2/3 of the incentive. Return to Top

7. **If a Nurse Practitioner (NP) works in a Family Practice office where the physician patient volume threshold meets 30%, but the NP Medicaid patient volume is only 28% and bills under the physician, does the NP qualify for an incentive even though she does not meet the 30% patient volume?**

No, a NP must meet 30% Medicaid patient volume to be eligible for the incentive program. (see 495.304 (c) (1) at 75 FR 44578). Billing provider information is only used when an Individual uses the group patient volume to meet eligibility. This is not based on a group scenario as the two individuals have different patient volumes. Return to Top

8. **I know at one point Behavior Health/Psychiatrist were excluded from being eligible physicians for HITECH. Is this still the case or are psychiatrists eligible**

Mental health providers would only be eligible for incentive payments if they meet the criteria of Medicaid eligible professionals (EPs). The incentive is calculated based on Medicaid services provided by eligible providers, which were legislatively defined as physicians, dentists, and other clinicians, but not psychologists, substance abuse counselors, or social workers. Physicians who work in behavioral health outpatient settings may apply for the incentives and reassign the funds to their employer, but most other behavioral health clinicians are ineligible. However, patient encounters rendered by the behavioral health clinicians may be counted in the patient volume. Return to Top

9. What is the first step in getting started? Is there a number I can call for more information?

Anyone interested in applying for the incentive program will first need to register at the **Center for Medicare and Medicaid Services (CMS)**. Registration will be forwarded from CMS and Providers can then complete an application by logging onto Interactive Services, then into MAPIR (Medical Assistance Provider Incentive Portal). Return to Top

10. I noticed on your website that EPs must verify they have paid at least ($3,750 for year 1 and $1,500 for year 2 through 6). If a Hospital or Home Office paid for the technology, is the EP still eligible for incentive payments for EHR technology?

This no longer requires verification. CMS has assumed an average allowable cost for providers that satisfy this requirement. Return to Top

11. Is a PA in a FQHC eligible for incentives only if the PA is the patient's primary provider or does the PA have to be the primary provider of the FQHC?

PAs are not eligible for incentives. The Final rule says that a PA is eligible only when practicing at a Federally Qualified Health Center (FQHC) that is led by a PA and if the individual provider is within the scope of practice defined under state law. Currently, there are no FQHC's in Delaware that are led by a PA as defined in the CMS Final Rule. Additionally, PAs are not within the scope of practice defined under Delaware Medicaid Regulations. DMAP enrolls PAs for Medicare Crossover only services to allow payments for the client's co-insurance and/or deductible. Return to Top

12. If a patient's primary provider is a physician but the patient is occasionally seen by a PA, would the PA qualify for incentives?

No, see answer to FAQ #11. Return to Top

13. Are PAs in physician offices, other than a FQHC qualified for incentives?

No, see answer to FAQ #11. Return to Top

14. Is there any issue with EPs applying for Medicaid incentives and being associated with the same TIN as the hospital that will also be applying for MU incentives?

No, the TIN is only used for payment of incentives. The hospital can receive incentive payments under this TIN and Eligible professionals can assign payments to this TIN if they choose. Return to Top

15. We know that the billing provider NPI # is used to verify patient volume for EPs that choose to use group encounters to meet eligibility requirements.

a) Does this mean the TIN has no bearing on eligibility requirements?

Correct.

b) Will EPs use the billing provider NPI # for their main satellite office if they want to apply using group encounters or will they use the billing provider NPI#s of all 4 locations together?

Group practice may determine the volume of Medicaid and total encounters for the group and allow their providers to use this volume. This is not dependent on the service locations as there could be one or many locations for the group. Medicaid expects groups to be enrolled with the NPI that represents the group and is used for billing for the individual provider's services in that group. If a provider is a member of multiple groups that are allowing the group volume to be used for this program, the EP should select only one group volume to report. This is sufficient to make them eligible to participate in the program. Meaningful use must be met at the individual level to receive an incentive. See the**CMS Frequently Asked Questions**.

c) Several physicians practice at multiple locations. Will they use the billing provider NPI # of all locations where they work to calculate group patient volume?

Group practice may determine the volume of Medicaid and total encounters for the group and allow their providers to use this volume. This is not dependent on the service locations as there could be one or many locations for the group. Medicaid expects groups to be enrolled with the NPI that represents the group and is used for billing for the individual providers services in that group. If a provider is a member of multiple groups that are allowing the group volume to be used for this program, the EP should select only one group volume to report. This is sufficient to make them eligible to participate in the program. Meaningful use must be met at the individual level to receive an incentive. See the**CMS Frequently Asked Questions**.

d) If a provider uses group volumes is the provider required to select the group as the payee?

No, EPs can decide to assign the payment to the group or receive the payment themselves. Payment designation is made as part of the federal registration and attestation process (R&A). Return to Top

16. If EP's in a group have attested to program year 1 and a new EP joins the group, can the new EP attest to AIU or will the EP be required to attest to MU?

The new EP may attest to AIU. Return to Top

17. As the non-EHR professionals adopt EHR technology (sharing the same TIN # as the EHR early adopters), will their Medicaid patient volume percentages affect the group practice volume percentages if the group practice qualifies as a group meeting the 30% Medicaid threshold?

The encounter volume is for all individuals within the practice and is not based on the quantity of the individuals that seek the incentive payment. The entire encounter volume including the non-EHR professionals Medicaid patient volume would have been originally included in the group practice volume. Return to Top

18. One physician sees patients in a traveling van and all of his patients are considered charity care. Will he be eligible for Medicaid incentives based on the needy individual's definition: patients furnished uncompensated care by the provider or services at no cost?

No, the needy individual's definition applies to FQHC volume only. Return to Top

19. For the first participation year, an EP only has to Adopt, Implement, or Upgrade an EHR to receive incentives. For the following years, the EP must meet certain objectives and measures during a specified EHR reporting period. For participation year 2 and later, if a physician practices at several locations, will all locations be taken into consideration to meet the objectives or will only the primary practice location be utilized?

Providers who practice at multiple locations must have 50 percent of their total patient encounters at locations where certified EHR technology is utilized to meet meaningful use requirement.

a. In order to demonstrate that at least 50% of all encounters occur in a location(s) where certified EHR technology is being utilized, must a provider include all locations even if a single location represents over 50% of the patient encounters?

The provider has to attest to using data from all locations with CEHRT and not just a single location that represents over 50% of patient encounters. For example, if a provider sees patients in 3 locations and 60% of patient encounters occur in Location A which has CEHRT, 20% of patient encounters in Location B which has CEHRT and 20% of patient encounters in Location C which has CEHRT, the provider must include data from Location A, Location B and Location C. They cannot just choose Location A because it totals over 50%. The data must include both a numerator and denominator. Return to Top

20. For a FQHC, do free care encounters, charity care encounters, and sliding scale encounters count toward meeting the 30% eligibility requirement?

Yes, this meets the CMS definition of "needy individual". Return to Top

21. How is an encounter defined for purposes of determining patient volume?

Federal rules allow the services below to be considered Medical Assistance encounters for calculating patient volume. For Eligible Professionals: Services rendered on any one day to an individual where Medical Assistance paid for part or all of the service or their premiums, co-payments and/or cost-sharing. For Hospitals: Services rendered to an individual per inpatient discharges where Medical Assistance paid for part or all of the service or their premiums, co-payments and/or cost-sharing. Services rendered to an individual in an emergency department on any one day where Medical Assistance paid for part or all of the service; or their premiums, co-payments and/or cost-sharing. Return to Top

22. Where can Meaningful Use standards be found?

Medical Assistance Meaningful Use requirements are posted on the CMS website:

Eligible Professionals Link

Eligible Hospitals Link

Guide to CQM's

Return to Top

23. **What are the requirements for Stage 1 of Meaningful Use?**

For EPs, there are a total of 25 meaningful use objectives. To qualify for an incentive payment, 20 of these 25 objectives must be met.

a) There are 15 required core objectives.
b) The remaining 5 objectives may be chosen from the list of 10 menu set objectives.

For eligible hospitals and CAHs, there are a total of 24 meaningful use objectives. To qualify for an incentive payment, 19 of these 24 objectives must be met.

a) There are 14 required core objectives.
b) The remaining 5 objectives may be chosen from the list of 10 menu set objectives.
Return to Top

24. **What are the different Stages of the EHR Incentive Program?**

The criteria for meaningful use will be staged in three steps over the course of the next five years.

- Stage 1 sets the baseline for electronic data capture and information sharing.
- Stage 2 (beginning in 2014) Advance clinical processes.
- Stage 3 (expected to be implemented in 2016) Improved outcomes.

Return to Top

25. How long does a provider need to keep documentation supporting their EHR program application?

Providers are required to retain documentation in support of all attestations for no fewer than six years after each payment year. Return to Top

26. For MU measure reporting in MAPIR will the percentages round up?

The on-line application (MAPIR) only rounds down to the whole number. For example, if the MU Measure report states 29.8% for a measure, MAPIR would calculate that as 29%. The rule requires that measures be met at “more than” the specified threshold. So in this example, if the measure requires more than 30%, your percentage must be at least 30.01 to meet the measure. MAPIR will display the percentage at 30% but will pass the measure. If your percentage is 29.8%, MAPIR will display 29% and the measure will fail.
Return to Top

27. If an eligible professional (EP) sees a patient in a setting that does not have certified electronic health record (EHR) technology but enters all of the patient's information into certified EHR technology at another practice location, can the patient be counted in the numerators and denominators of meaningful use measures for the Medicare and Medicaid EHR Incentive Programs?

Starting in 2013, an EP must have access to Certified EHR Technology at a location in order to include patients seen in locations in the determination of eligibility and to count towards meaningful use. EPs will not be able to include patients seen at locations where they do not have access to Certified EHR

Technology. Access to Certified EHR technology can be in any manner such as the location hosting Certified EHR Technology, the EP bringing their Certified EHR Technology to the location on a portable device, or the EP having access to their Certified EHR Technology remotely at the location using devices available at the location. Return to Top

28. For eligible professionals (EPs) who see patients in both inpatient and outpatient settings (e.g., hospital and clinic), and where certified electronic health record (EHR) technology is available at each location, should these EPs base their denominators for meaningful use objectives on the number of unique patients in only the outpatient setting or on the total number of unique patients from both settings?

In this case, EPs should base both the numerators and denominators for meaningful use objectives on the number of unique patients in the outpatient setting, since this setting is where they are eligible to receive payments from the Medicare and Medicaid EHR Incentive. Return to Top

29. **How should eligible professionals (EPs) select menu objectives for the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs?**

EPs participating in Stage 1 of the EHR Incentive Programs are required to report on a total of 5 meaningful use objectives from the menu set of 10. When selecting five objectives from the menu set, EPs must choose at least one option from the public health menu set. If an EP is able to meet the measure of one of the public health menu objectives but can be excluded from the other, the EP should select and report on the public health menu objective they are able to meet. If an EP can be excluded from both public health menu objectives, the EP should claim an exclusion from only one public health objective and report on four additional menu objectives from outside the public health menu set.

EPs participating in Stage 2 are required to report 3 meaningful use objectives from the menu set of 6.

We encourage EPs to select menu objectives that are relevant to their scope of practice, and claim exclusion for a menu objective only in cases where there are no remaining menu objectives for which they qualify or if there are no remaining menu objectives that are relevant to their scope of practice. For example, we expect that EPs will report on 5 measures, if there are 5 measures that are relevant to their scope of practice and for which they can report data, even if they qualify for exclusions in the other objectives. Please note that EPs must have complete certified EHR technology (or a complete set of certified EHR modules) capable of supporting all of the core and menu set objectives, including any objectives for which the EP can claim an exclusion and menu set objectives the EP does not select.

Starting in 2014 for both Stage 1 and Stage 2, meeting the exclusion criteria will no longer count as reporting a meaningful use objective from the menu set. An EP must meet the measure criteria for 5 objectives in Stage 1 (3 objectives in Stage 2) or report on all of the menu set objectives through a combination of meeting exclusion and meeting the measure. Return to Top

30. If I am participating in the Medicaid Electronic Health Record (EHR) Incentive Program but also provide care to Medicare patients, am I subject to the Medicare payment adjustments?

Yes. While there are no payment adjustments under the Medicaid EHR Incentive Program, those Medicaid EPs who are also paid under Medicare could be subject to payment adjustments if they are not meaningful

EHR users for an applicable reporting period. Adopting, implementing and upgrading EHR technology is not considered meaningful use for these purposes. Return to Top

31. Are Medicaid eligible professionals and eligible hospitals subject to payment adjustments or penalties if they do not adopt electronic health record technology or fail to demonstrate meaningful use?

No, there are no payment adjustments or penalties specifically for Medicaid providers; however, if your practice accepts Medicare patients, please check the Medicare rule. Return to Top

32. Can an eligible professional or hospital charge patients a fee to have access to their online portal in the certified EHR technology solution?

CMS does not believe it would be appropriate for the EP or hospital to charge the patient a fee to access the Certified EHR Technology solution regardless of whether the solution is in the form of a provider-specific portal, an online personal health record, community portal or some other solution. Return to Top

33. Since providers now have a choice of volume reporting periods, can a provider use the same period for 2 program years?

No. Each program year requires a distinct volume reporting period. There can be no overlap of volume reporting periods. Return to Top

If you need assistance selecting and using an EHR system, contact the **Delaware Regional Extension Center**

If you would like more information on the DMAP Provider Incentive Program for Electronic Health Records please direct your inquiries to **Delaware Provider Incentive Payment Team**